

**South Carolina Department of Disabilities and Special Needs
Early Intensive Behavioral Intervention
Provider Renewal Form**

Date: _____

Name: _____

Mailing Address: _____

Phone: _____ Fax: _____

E-Mail Address: _____

***Note:** Submission of 20 continuing education units (CEUs) documentation is required during a two-year period as one part of the renewal process. A review of the provider's work to be completed by DDSN is the second part of the process for renewal and continued provider status.*

Signature: _____ Date: _____

Certification of Applicant: By my signature, I affirm, agree, and understand that all information on this form is true and accurate. Any misrepresentation, falsification, or material omission of information on this form may result in exclusion from further consideration or if approved, termination of provider status.

Mail this form to:

**Daniel Davis
South Carolina Department of Disabilities and Special Needs
Director, Autism Division
3440 Harden Street Extension
P.O. Box 4706
Columbia, SC 29240**